The Health Benefit Exchange and the Commercial Insurance Market

Overview

The federal health care reform law directs states to set up health insurance marketplaces, called "Health Benefit Exchanges," that will enable individuals, families and small employers to shop for health insurance. The law allows states to defer to the federal government to operate an Exchange if a state chooses not to establish one; however, Nevada has decided to administer its own Exchange and is in the process of establishing the "Silver State Health Insurance Exchange."

Starting in 2014, Nevadans who today cannot afford health insurance or are denied coverage due to poor health or a pre-existing condition will be able to purchase health insurance. The Exchange will serve as a central point of access to health coverage for tens of thousands of Nevadans. A recent report estimates that approximately 200,000 residents may purchase commercial health plans through the Nevada Exchange.

Lower- and middle-income individuals and families with annual income up to four times the Federal Poverty Level (FPL) – which for a family of four is $89,400 in calendar year 2011 – may be eligible for subsidized health insurance through the Exchange. In addition to premium subsidies, the Exchange's health plans will include limits on members' cost sharing (e.g., co-payments, co-insurance, and deductibles) and total out-of-pocket expenses. Small employers with lower-wage workers that purchase employer-sponsored insurance (ESI) through the Exchange may be eligible for premium subsidies for up to two years.

In addition to the establishment of the Exchange, the federal health care reform law makes a number of significant changes to the way health insurance is regulated, and these changes will have a profound effect on Nevada's commercial health insurance markets. Among the key provisions, the federal law:

- Requires the Exchange to "certify" and make available "qualified health plans;"
- Limits who can purchase coverage through the Exchange to individuals, families and small employers (i.e., businesses with 50 or fewer workers), at least initially;
- Alters the way health plan rates are set, eliminates medical underwriting, and requires that plans in the individual market be made available on a "guaranteed issue" basis;
- Mandates the public disclosure of health insurers' data;
- Directs the Exchange to annually rate health plans based on quality and price, and for the Exchange review premium increases; and
- Establishes risk mitigation measures to reduce insurers' financial exposure.

These issues are discussed briefly below.

Certifying and Making Available Qualified Health Plans

The Exchange will offer health plans in five benefit levels: Platinum, Gold, Silver, Bronze, and Catastrophic. The benefit levels will vary based on "actuarial value," which is a measure of the amount of medical claims paid by the health plan (not including member cost sharing), expressed as a percentage of the total medical claims incurred for a standard population.

Platinum plans will cover 90 percent of the cost of care, which means a person enrolled in a Platinum level plan, on average, would pay ten percent of the cost of health care through co-payments, co-insurance and other types of cost sharing. The health plan's premiums would cover the rest of the cost of care.

Gold plans will cover 80 percent, Silver plans will cover 70 percent, and Bronze plans will cover 60 percent. Catastrophic plans, which are high deductible health plans (HDHPs), will also be available to individuals under 30 years of age and to people who are exempt from the insurance mandate due to affordability or other hardship.[1]

The law requires participating insurers to offer at least one plan at the Gold and Silver levels. An important policy decision for Nevada will be whether the Exchange will require insurers that wish to participate to offer health plans in all of the coverage tiers (i.e., Platinum, Bronze and Catastrophic, as well as Gold and Silver).

Another key decision for Nevada's Exchange will be the extent to which benefits are standardized within each benefit level (e.g., the amount of cost sharing for different services, and the types of plans offered – HMO, PPO, Indemnity). The federal law provides some flexibility with regard to the plans offered and the cost sharing, within the actuarial value parameters set by the law and the "essential health benefits" requirements (discussed below).

Essential Health Benefits: The federal law requires the Exchange to offer "qualified" health plans in the coverage tiers described above, and those plans must cover "essential health benefits." The terms "qualified" and "essential health benefits" will be further defined by the federal Secretary of Health and Human Services (HHS), as well as the Nevada Exchange. The law[2] does, however, enumerate a number of services that must be covered by health plans offered through the Exchange, including:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care

[1] A high-deductible health plan (HDHP) offered through the Exchange must cover all of the essential health benefits, as determined by the secretary of HHS, but may have larger up-front deductibles and a lower actuarial value than the Bronze level plans. In 2010, HDHPs could have deductibles of $5,950 (individual) and $11,900 (family).

[2] Section 1302 of the Patient Protection and Affordable Care Act (ACA).

- Mental health and substance abuse services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

In addition to these federal requirements, Nevada may require that health plans cover additional benefits or services. The State currently has a number of mandated benefits that must be covered by commercial health plans. However, for coverage sold through the Exchange, the federal law requires that the cost of any mandated benefits that exceed the federally-defined essential health benefits must be paid for by the State.

Nevada will need to carefully review the federal essential health benefits and compare these requirements to the State's mandated benefits. A policy decision will then need to be made regarding whether the State will continue to require health plans to cover benefits and services above and beyond the essential health benefits; and, if so, how will the State pay for those benefits for the policies purchased through the Exchange.

While the law imposes new regulatory requirements on all health insurers (discussed briefly below), health plans offered through the Exchange must also meet additional requirements, including marketing standards, network adequacy, accreditation, and quality improvement programs. The Exchange may certify plans for participation only if it "determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates."[3]

The law also requires health insurers that are seeking certification as a "qualified health plan" to submit to the Exchange a justification for any premium increase prior to implementation of the increase, and health insurers are required to "prominently post such information on their websites."[4] The Exchange is to take this information – along with information and recommendations provided by the State Division of Insurance relating to patterns or practices of excessive or unjustified premium increases – into consideration when determining whether to make such health plan available through the Exchange.[5]

Health insurers will also be required to submit and make public information to the Exchange, the Nevada Division of Insurance, and the Secretary of HHS, including:

i. Claims payment policies and practices;
ii. Periodic financial disclosures;

[3] Section 1311 (e) (1) of the ACA.
[4] Section 1311 (e) (2) of the ACA.
[5] Jost, T.S., "Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues," The Commonwealth Fund, September 2010.

iii. Data on enrollment and disenrollment;
iv. Data on the number of claims that are denied;
v. Data on rating practices;
vi. Information on cost-sharing and payments with respect to any out-of-network coverage;
vii. Information on enrollee and participant rights; and
viii. Other information as determined appropriate by the Secretary.

Given the Exchange's ability to offer premium subsidies to low- and moderate-income individuals and families, insurers offered through the Exchange will likely have access to a large group of new consumers. This heightens the responsibility of Nevada's Exchange to establish a fair and open certification process for all qualified health plans.

The Exchange's Target Markets

The Exchange is allowed to offer health insurance to individuals and families in the individual market and to small employers in the small group market. People purchasing coverage in the individual market may be eligible for premium subsidies and reduced point-of-service cost sharing if they meet certain eligibility requirements. Legal Nevada residents with income up to 400% FPL who are not eligible for Medicaid and are not offered "affordable" employer-sponsored insurance (ESI) may purchase subsidized coverage through the Exchange. Legal residents who are not eligible for premium subsidies will also be allowed to purchase health coverage through the Exchange.

For the first two years (i.e., 2014 and 2015), the Exchange may limit its employer market to firms with 50 or fewer employees, as is currently the case in Nevada's small group market. However, in 2016, the federal law dictates that employers purchasing through the Exchange must include businesses with up to 100 employees. In 2017, the Exchange may choose to sell insurance to larger employers (i.e., more than 100 employees).

Changes to the Individual and Small Group Market Regulations

The federal law brings sweeping changes to the regulations governing the individual and group markets, with many of the most significant changes taking effect in 2014. Below is a brief overview of Nevada's existing rules and upcoming changes that will affect the individual and small group markets.

Small Group: The small group market in Nevada is governed by specific rating rules established by State law and regulated by the Nevada Division of Insurance (DOI). Small groups include firms with 2 to 50 employees. Health insurance is sold on a guaranteed issue basis, with a maximum exclusion period of 12 months for pre-existing conditions and lapsed coverage. Guaranteed issue means that carriers licensed to sell insurance in the State must offer coverage to all applicants, regardless of the health, age, gender, or other factors that may indicate a person's potential need for health care and utilization of health services.

All rates and premium increases for HMOs sold in Nevada's small group market are required to be approved by the DOI prior to use. Other plan types (i.e., PPO carriers) are not required to file their products for rate review by the Division prior to use, although the DOI is seeking this statutory authority and there is a bill (Assembly Bill 309) currently under consideration by the legislature.

Carriers are permitted under the current guidelines to develop premiums based on a number of specific characteristics. The factors used in developing rates include:

- The size of the group (the number of covered lives)
- The average age of the group
- The gender mix
- The industry to which the employer group belongs (carriers may establish no more than nine classes of business based on observed and demonstrated differences in cost – administrative or claims - or utilization)
- The geographic area of the State where employees are located
- The family composition of the group (e.g., individual, individuals +1, family)
- The employer's premium contribution level

Carriers must stay within certain parameters when structuring their rates. For example, for the industry classification, the rating factor for the *highest-risk industry type* may not exceed the rating factor for the *lowest risk industry type* by more than 20%. Premiums offered to *like-employers* (i.e., those within the same industry type) must be set within certain parameters. According to DOI, the various rating requirements "effectively allow carriers to rate for health status with a rating factor limit of 85.7% within each class of business." [6]

Nevada's laws limit the extent to which rate increases can reflect adjustments for factors such as claim experience and duration of coverage (which may not exceed 15% for a specific employer), premium differences for similarly situated groups, and changes in the demographics of the group.

Federal health care reform will alter these rules by restricting the number and types of rating factors used to set plan premiums in the small group market, as well as place limits on annual deductibles and the benefits that must be covered. In 2016, small employers will also be redefined as those with up to 100 employees. The table below summarizes the rating rules before and after full implementation of health reform in 2014.

	Before Federal Reform	**After Federal Reform**
Definition of "Small Group"	2-50 employees	Up to 50 employees in 2014 and 2015 (state option). In 2016 and beyond, up to 100 employees

[6] State of Nevada, Division of Insurance "Overview of Rating Rules in Nevada", 2011

Covered lives (September 2010)	102,728	Unknown
Guarantee issue	Yes	Yes
Guarantee renewal	Yes	Yes
Premium rating factors	• Group size • Age • Gender mix • Industry • Geography • Family composition • Employer's premium contribution	• Age 1:3 max ratio • Geography • Tobacco 1:1.5 (max) ratio • Family composition • Plan design
Annual deductible limits	None	$2,000 (individual) $4,000 (family)
Benefits included in the plan	State mandates, as applicable	State mandates and "essential health benefits," to be defined by the US Secretary of Health and Human Services
Number of carriers	18	Unknown

Individual Market: Unlike the small group market, there is no guaranteed issue requirement for plans sold in the State's individual market. In Nevada, carriers may take a number of factors into consideration when establishing premiums, and health insurers can deny coverage to applicants that they deem are not insurable, based on the applicant's health status or pre-existing medical condition. Insurers may also charge higher premiums to individuals and families based on their health status.

Carriers who sell individual market products in Nevada may use the following rating factors:

- Age
- Gender
- Occupation,
- Location of residence (geographic factor),
- Composition of the applicant's family; and
- Health status

The Division of Insurance retains the right to approve all rates in the individual market and all rate changes must be filed with the Division and approved prior to use. Carriers must submit complete rate history, actuarial assumptions, incurred and paid claims, earned premium, information on the

medical trend, and other factors being used. The Division has 60 days to respond to the applications of commercial carriers and 30 days for nonprofits.[7]

As with the small group market, there are certain rate bands or parameters that the carriers' underwriters must operate within. Specifically, the rating factor that is used for the highest risk members may not exceed the rating factor used for those classified as the lowest risk by more than 75%. Carriers may also pool individual plan members within *blocks of business*; however, the rating factor used for one block of business may not exceed another by more than 50%.[8]

Federal health care reform will require major changes to the way individual health insurance is sold and the rating rules that will apply in Nevada's individual market. The most significant change will be the elimination of medical underwriting and the new requirement that policies be sold on a guaranteed issue basis.

	Before Federal Reform	**After Federal Reform**
Covered lives (September 2010)	87,309	Unknown
Guarantee issue	No (those with pre-existing conditions may be denied coverage)	Yes
Premium rating factors	• Age • Gender • Occupation • Geography • Family composition • Health status	• Age 1:3 (max) ratio • Geography • Tobacco 1:1.5 (max) ratio • Family composition • Plan design
Benefits included in the plan	State mandates	State mandates and "essential health benefits," to be defined by the US Secretary of Health and Human Services
Number of carriers	28	Unknown

Risk Mitigation Provisions

As discussed above, Nevada insurers are currently allowed to set premiums in the individual and small group markets based, in part, on the health status of applicants or small employer groups; they

[7] State of Nevada, Division of Insurance "Overview of Rating Rules in Nevada", 2011
[8] State of Nevada, Division of Insurance "Overview of Rating Rules in Nevada", 2011

are allowed to raise premiums if individuals or small group members become ill; and they are not required to accept all applicants for coverage in the individual market (i.e., no guaranteed issue requirement).

Under federal health care reform, medical underwriting will no longer be allowed in the individual and small group markets. In 2014, health insurance policies in these markets will be guaranteed issue using a modified community rating system to set premiums. Premiums will still vary, primarily based on the age of the applicant; however, the health status of individuals or groups will not be a factor in the development of premiums.

These changes in the rating rules will mean that individuals and small employers who are currently unable to purchase insurance or who are effectively priced out of the market due to health status or pre-existing condition may be able to purchase coverage. It will also mean that individuals and small employers who have coverage today may see their premiums adversely affected, due to the addition to the individual and small group market risk pools of people who had previously been denied coverage due to their medical conditions. For example, people covered in Nevada's federally-administered high risk pool (i.e., the Pre-existing Condition Insurance Plan or PCIP) will be able to purchase coverage through the Exchange and will become part of the individual market risk pool.

The law recognizes that these changes to Nevada's individual and small group market rules may cause risk selection problems for some insurers. To mitigate the impact of these changes, the health care reform law includes three mechanisms to address risk selection and provide some financial protection for insurers:

- Transitional reinsurance program for the individual market in each state;[9]
- Risk corridors in the individual and small group markets;[10] and
- Risk adjustment to transfer funds among health plans that offer coverage in the individual and small group markets based on the relative health status of their enrollees.[11]

These provisions of the health care reform law are designed to address the adverse risk selection problems that may result from the switch to a guaranteed issue, modified community rating system. Each is briefly described below.

Reinsurance: For the first three years of the Exchange (1/1/2014 – 12/31/2016), states are required to establish a reinsurance program for the individual market. A reinsurance entity will collect payments from insurers in all markets (i.e., the individual and group markets, as well as from third party administrators) and make reinsurance payments to the insurers in the individual market to cover the costs of high-risk individuals. The Secretary of Health and Human Services (HHS), in consultation with the National Association of Insurance Commissioners (NAIC) and the states, will develop

[9] Section 1341 of the ACA.
[10] Section 1342 of the ACA.
[11] Section 1343 of the ACA.

guidelines and the methodology for the transitional reinsurance program. The Secretary of HHS will also provide the methodology used to determine how much insurers are to contribute to the reinsurance program.

Risk Corridors: The Secretary of HHS is required to establish a national risk corridors program for qualified health plans in the individual and small group markets that will be effective in 2014 through 2016. If a health plan's "allowable" (i.e., non-administrative) costs in the individual and small group markets exceed 103 percent of total premiums (excluding administrative costs), the Secretary of HHS will make payments to the health plan to defray the excess costs. Conversely, if a plan's non-administrative costs are less than 97% of total premiums (excluding administrative costs), the health plan will need to pay a portion of the excess premiums to the Secretary of HHS.

Risk Adjustment: Finally, the State, in consultation with the Secretary of HHS, will be required to establish a risk-adjustment program for the individual and small group markets. The risk adjustment program will assess charges on health plans with enrollees of lower-than-average risk and make payments to health plans with enrollees of higher-than-average risk. The risk adjustment provision will not apply to "grandfathered" plans, which are health plans that may be sold that do not include all of the new requirements of the ACA.

All three risk mitigation provisions will apply across the (non-grandfathered) individual market, including qualified health plans offered inside the Exchange, as well as individual market health plans offered outside the Exchange. The Risk Corridors and Risk Adjustment provisions will apply to products offered in the (non-grandfathered) small group market, which are sold both inside and outside the Exchange.

This high-level overview of the Exchange and the Nevada insurance market raises a number of key issues and policy decisions that the State, and the Exchange, will need to make leading up to the introduction of the Exchange and the regulatory changes that will take effect in 2014. Listed below are a few of the key issues/questions that policymakers and stakeholders will need to consider.

<u>Key Issues for Nevada</u>

- How will changes to the rating and underwriting requirements in the individual and small group markets affect premiums for people currently purchasing insurance in Nevada?
- What criteria should the Nevada Exchange use to certify qualified health plans?
- Within each coverage tier (Platinum, Gold, Silver, Bronze, and Catastrophic), how much variation in plan design should be allowed or should the Exchange dictate the levels and types of cost sharing within each coverage tier?
- How can the Exchange attract a broad and diverse risk pool?

- For small employers, how much choice should the Exchange allow in terms of the health plans made available to employees?
- Should the Exchange establish minimum contribution and minimum participation requirements for small employers seeking to purchase health coverage through the Exchange?
- How many people are susceptible to switching their source of coverage (e.g., from employer-sponsored insurance to an individual product offered through the Exchange or to other publicly subsidized coverage) and should the Exchange establish policies and procedures to minimize disruption to the existing markets?
- Should the individual and small group markets be merged, and, if so, what might be the impact to premiums in each market?
- Should groups of more than 50 employees be prohibited from purchasing coverage in the small group market during the first two years of the Exchange?
- Will the inclusion of groups of 51–100 have a positive or negative effect on the small group risk pool, and how will premiums be affected?
- Overall, what may be the role of the Silver State Health Insurance Exchange within Nevada's commercial health insurance market, and will the Exchange be proactive in encouraging carriers to develop and offer innovative plan designs?